DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 05-003

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 16, 2005

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2005 $0
b. FFY 2006 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
State Governor's Review

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Shannon Turner, ~~J.D.~~

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 3-28-05

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 29, 2005

18. DATE APPROVED: April 12, 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 16, 2005

20. SIGNATURE OF REGIONAL OFFICIAL: Judy E. Nobles for Renard Murray

21. TYPED NAME: Renard L. Murray, D.M.

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

Citation	7.4 State Governor's Review
42 CFR 430.12(b)	The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

_X_ Not Applicable. The Governor-

_X_ Does not wish to review any plan material.

___ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services
(Designated Single State Agency)

Date: January 16, 2005

(Signature)

Shannon Turner, Commissioner
Department for Medicaid Services
(Title)